



PRR

Psychiatric Research Report

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PRR — Psychiatric Research Report

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A Note from the Executive Editor

Darrel Regier, M.D., M.P.H.

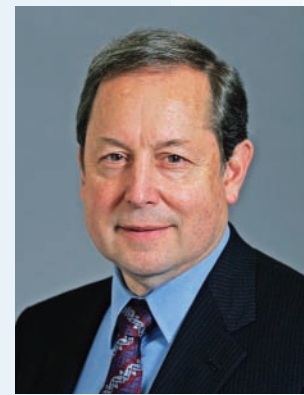
Executive Director, American Psychiatric Institute for Research and Education;
Director, APA Division of Research

As the May 2012 deadline for publication of DSM-V looms nearer, questions are swirling about how the classification of psychiatric illnesses will be presented. In a recently published commentary in the *American Journal of Psychiatry* (Regier et al., June 2009; 166:6), we outlined our conceptual approach to DSM-V development and its implications for the future. In this brief note, I'd like to highlight some of our major considerations.

Historically, the Feighner criteria developed in 1972 and the Research Diagnostic Criteria (RDC) provided the basis for DSM-III's introduction of explicit diagnostic criteria. While it has become clear that reliability across clinical and research settings has been achieved, the diagnostic categories have fallen far short of the proposed Robins and Guze 1970 criteria for validating them. Findings from numerous large-scale epidemiological, clinical, and neuroscience studies have failed to confirm the validity of DSM-III and DSM-IV's "pure" diagnostic categories. More than a third of patients discharged from academic health centers, for example, leave with a Not Otherwise Specified (NOS) diagnosis. Similarly, co-morbidity has emerged as the rule rather than the expected clear separation of disorders anticipated by the diagnostic and statistical manual's explicit criteria.

To address these concerns, we are viewing the DSM-V revision process as an opportunity to assess nearly 40 years' worth of research findings to determine what, in fact, fits clinical reality and what does not. Our proposed criteria, like the Feighner, RDC, and previous DSMs, will not be written in stone, but are being conceived as working hypotheses, readily testable for their validity throughout the coming years.

A major impetus emerging from our reviews of research findings was the recognition of the need to incorporate dimensional assessments of mental disorders. For DSM-V, this will include consideration of symptom dimensions to determine disorder severity. Other cross-cutting dimensions will facilitate the measurement of symptoms not contained in the categorical diagnostic criteria for a given diagnosis, such as an anxiety assessment for patients with a mood disorder. Some of these dimensional assessments are being developed as "core" dimensions that measure psychiatric symptoms pertinent to all patients, much like general medicine's "review of systems." For adult diagnoses, the core dimensions will likely include anxiety, depressed mood, suicidal ideation, cognitive status, and sleep disturbance, among others.



...emerging from our reviews of research findings was the need to incorporate dimensional assessments of mental disorders.

The inclusion of dimensional measures represents an opportunity to address some long-standing and thorny problems with current criteria—excessive comorbidities, “not otherwise specified” diagnoses that are meaningless for clinical and research purposes, and inadequate specification of atypical, mixed, and mild disorders. Dimensional criteria also should better aid researchers who have been hindered by categorical criteria that do not parallel emerging findings from genetics and neuroscience, such as the overlap in genetic risks for schizophrenia and bipolar disorder. Dimensional assessments have already demonstrated their utility and increasing acceptance, and we are optimistic about their potential for improving screening, diagnosis, and treatment for all patients.

These dimensions, as well as proposed additions and deletions to criteria, will be scrutinized over the next 15 months during field trial testing. These field trials will not be used to develop criteria, but will help determine whether draft criteria are reliable and clinically useful. It’s also important to note that these proposed changes are not being made haphazardly. They are based on 10 years of publications from the National Institutes of Health/World Health Organization-sponsored research planning conference series, as well as more recent extensive focused literature reviews from the DSM-V Work Groups. The planning conferences were particularly invaluable in appraising the state of the science, and we are pleased that approaches from several of the conferences, such as the suggestion for increased examination of neurocircuitry among stress-related and fear-based disorders has been adopted by the National Institute of Mental Health in their development of the forthcoming Research Domain Criteria. We hope that this NIMH effort will provide support for future revisions of the DSM-V which is being planned as a “living” document in which individual diagnostic areas will be revised as the research base permits—much more like the periodic revisions of the APA Practice Guidelines.

We are now entering a phase that holds both great excitement and considerable challenges. Any revision of diagnostic criteria is of enormous interest to the field, and more often than not, controversial. Please be assured that as we continue our efforts to develop a scientifically sound DSM-V, we will be relentless in adhering to our fundamental principles of introducing only empirically-based revisions and upholding the manual’s clinical utility. As we have throughout this process, we will be seeking feedback from colleagues during field trials. Recommendations may also be submitted through our Web site, www.dsmv.org.



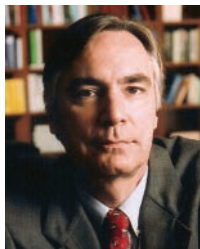
Darrel A. Regier, M.D., M.P.H.

Your feedback is very important to us. Let us hear from you at prrr@psych.org

Report from the ECT Committee: Reclassifying ECT Devices

William MacDonald, M.D.

Chair, Corresponding Committee on Electroconvulsive Therapy and Other Electromagnetic Therapies



The APA's Task Force to Revise the Practice of Electroconvulsive Therapy (ECT) has been meeting for the past year to update the ECT practice guidelines which are scheduled to be published in 2010. There have been a number of important research findings since the time of the last published APA Guidelines in 2002. These findings include the introduction of bifrontal electrode placement, development of ultrabrief pulse stimulus, and additional data on cognitive changes associated with ECT, use of pharmacologic agents to enhance ECT response, relapse prevention after ECT and anesthetic agents used during ECT. As the first draft of the 2010 Guidelines is being prepared, the Task Force is seeking input from a variety of experts in the field of psychiatry, consumer groups and allied groups in ECT practice including anesthesia.

The 2010 update comes at a critical time in the practice of ECT. The FDA is presently accumulating data to determine if ECT devices should be reclassified. ECT devices were originally classified as Class III devices in 1978. Class III devices on the market prior to 1976, such as ECT machines, were not initially required to submit to the rigorous pre-market approval process now required for newer Class III devices. However, under the Safe Medical Devices Act of 1990, FDA is required to review information related to the safety and efficacy of these "grandfathered" devices and reclassify

them based on this data. FDA requested that manufacturers submit information about the devices by August 7, 2009, which will be used to ascertain whether such devices will be reclassified to a less restrictive category (Classes I or II), or remain in Class III.

If not reclassified, devices will be immediately required to submit for premarket approval which would include a potentially expensive premarket approval process. This scenario could threaten the availability of ECT in the USA, since the ECT manufacturers, which are very small companies, likely lack the resources to comply with a full-blown pre-market approval process. While FDA did not formally seek any input from stakeholders other than manufacturers, APA has remained in close contact with the Agency on this issue and has been assured that there will be an upcoming opportunity to comment on any proposed reclassification. APA will be engaging with FDA and expressing our support for the technology being reclassified as a Class II device and making it clear that it is essential that this technology be available to the field and to the many patients it benefits.

The original ECT Task Force for the Development of a Safety and Performance Standard for ECT Devices was formed in 1978 in response to the original FDA evaluation for ECT device classification. The 2009 ECT Task Force will also be an important resource for the APA in the present FDA evaluation of the safety and efficacy of ECT devices.

Info:

The complete FDA Federal Register notice regarding Class III medical devices can be read online at <http://edocket.access.gpo.gov/2009/pdf/E9-8022.pdf>

DSM-V: An Open Forum at the Annual Meeting

As part of efforts to make DSM-V development an open and inclusive process, members of the DSM-V Task Force and Work Group participated in a town-hall style forum at APA's annual meeting in San Francisco. The forum, which drew hundreds of attendees and featured a question-and-answer session from the audience, opened the DSM-V Track symposia series.

DSM-V Task Force chair David J. Kupfer, M.D., and DSM-V Task Force vice-chair Darrel A. Regier, M.D., M.P.H. each provided a brief overview of the development process and current activities. Among the highlighted activities was the integration of dimensional assessments within and across diagnoses to better capture gradations of psychopathology, including comorbid symptoms/diagnoses, assessment of impairment and functioning, and diagnosis severity. Many of the questions and comments from the audience related to diagnostic dimensions.

A panel comprised of Katharine A. Phillips, M.D., chair of the DSM-V Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group; William T. Carpenter, M.D., chair of the DSM-V Psychotic Disorders Work Group; and Jan Fawcett, M.D., chair of the DSM-V Mood Disorders Work Group, described some of their specific group's discussion topics before fielding questions from the audience.

Among the questions was whether novel findings in genetics would be used in the classification and grouping of anxiety disorders. Dr. Phillips commented that "there have been amazing advances in neuroscience and endophenotypes and genetics," but she questioned whether the field is ready to incorporate such information. "It's not clear that there are enough replicable, sensitive findings to incorporate into criteria specifically," but, she added, "we may be able to mention relevant data in the text."

When Dr. Carpenter was asked whether cognitive dysfunction in schizophrenia would be a possible dimension or a diagnostic symptom, he said, "Cognitive changes are a core pathological feature of many disorders, but will not work as a diagnostic criterion. Simply put, everyone has an IQ, and you can't tell someone's diagnosis by their IQ. Many disorders have cognitive problems. It's a vitally important dimension, but it can't help with differential diagnosis per se."

The Mood Disorders Work Group is considering dimensions as a means of elucidating comorbid conditions that may impact symptom presentation and treatment outcome, such as drug and alcohol dependence. "We would like to see substance abuse as a dimension (in the assessment of mood disorders) because it predicts so much," Dr. Fawcett stated, "but it has to be useful for clinicians."

Dr. Fawcett also addressed variations in suicidal behavior, notably suicide associated with a clear depressive state versus non-depression related impulsive suicide. He suggested that an impulsivity dimension within depression might help better address this distinction and that the mood disorders work group is considering several dimensions for upcoming field trials.

Two DSM-V symposia followed the research forum — one on the implications of listing or removing gender-identity disorder from DSM-V, and a second highlighting presentations on cross-cutting dimensions in DSM-V from the recent American Psychopathological Association's annual meeting in March. In addition to reviewing current problems with the diagnostic system in DSM-IV, both sessions featured discussions about possible strategies for revisions of the upcoming edition of DSM. Rounding out the DSM-V Track was a symposium on public health aspects of mental

Highlights

- Classification and grouping of anxiety disorders
- Cognitive dysfunction in schizophrenia
- Substance abuse dimensions
- Variations in suicidal behavior

diagnosis and nosology.

“With each year, the DSM-V sessions are increasing in attendance and in audience interest,” said Dr. Regier, M.D., who is also Executive Director of the American Psychiatric Institute for Research and Education. “It’s intellectually stimulating for those of us involved in DSM-V to share our strategies and receive feedback from the clinicians and researchers who will be affected by decision-making at the Work Group and Task Force levels. And as we begin conducting field trials, this input will become even more valuable.”

DSM-V is scheduled for release at the 2012 Annual Meeting, May 5-10, in Philadelphia, PA.

Gender Identity Disorder and DSM-V: Controversy Continues

With interest in DSM-V already running high, this year’s DSM-V Track at the APA Annual Meeting attracted further attention with the symposium “In or Out? A Discussion about Gender Identity Diagnoses and the DSM.” The session was organized in response to a growing concern among members of the transgender community, advocates, and health care providers about how gender identity disorder (GID) will be addressed in DSM-V.

Conversations over whether to include or exclude GID from DSM-V have been intensifying over the past year. Those in favor of inclusion have emphasized the need for insurance coverage of psychiatric, medical, and surgical treatments for GID — virtually impossible without formal recognition of GID as a disorder. Those opposed argue that inclusion of GID in DSM-V identifies gender variance as a mental illness rather than as a non-pathological pathway in gender development.

In addition to discussing both sides of the argument, the symposium shed light on various issues under consideration by the members of the DSM-V Sexual and Gender Identity Disorders Work Group. Presenters also described how diagnostic

criteria and accompanying text descriptions might better reflect the current research about GID, should it remain in DSM-V. Further discussion detailed the potential emotional, social, medical, and legal ramifications, both positive and negative, of listing GID in the manual. As a reflection of the strong opinions regarding GID, a planned gathering outside the convention center protested the inclusion of GID in DSM-V.

“The fate of gender identity disorder in DSM-V has been one of the most emotionally charged issues that we have faced in the DSM revision,” said William E. Narrow, M.D., M.P.H., DSM-V Research Director and Associate Director of APA’s Division of Research. “The listing of this disorder in the DSM, the content of the diagnostic criteria, and the accompanying text all are being closely examined. Each member of the work group recognizes that there are not just clinical ramifications to their decisions, but also unique personal and social issues that affect each person who receives a diagnosis of GID. The members of the work group and the leadership of the DSM-V revision want to make sure that leaders of the transgender community have a voice in this process, and this annual meeting session was one way to do that.”

The session came on the heels of the Society for Sex Therapy and Research’s 2009 Annual Meeting, held in early April, at which members of the work group outlined potential plans for revisions to sexual dysfunctions, paraphilias, and GID. Public interest in the work group has grown since its membership was officially announced in April 2008.

DSM-V PRESENTATIONS AND CONFERENCES can be found by visiting the Web site www.dsmv.org.

“The fate of gender identity disorders in DSM-V has been one of the most emotionally charged issues we have faced...”

— William Narrow, M.D., M.P.H.

Reports from the Annual Meeting

Annual Meeting Update: HIV Psychiatry

The APA Annual Meeting in San Francisco provided an opportunity for the Office of HIV Psychiatry to update members on state-of-the-science diagnostic and treatment considerations for the clinical and neuropsychiatric dimensions of HIV disease. During a lively symposium that included representation from both psychiatry and internal medicine, a number of research findings, briefly outlined below, drew considerable attention and discussion.

... the long-term toxicity of anti-HIV medications is associated with... increases in blood cholesterol and lipid levels that translate into an increased risk for stroke and cognitive impairment

First, aging was cited as a more significant factor in specific types of HIV cognitive dysfunction than had been previously recognized. Research data also showed how the penetration of anti-HIV medications into the brain is clinically relevant for the prevention and treatment of these cognitive disorders.

Regarding treatment, it is now better understood that the long-term toxicity of anti-HIV medications themselves, particularly protease inhibitors, is associated not only with the externally disfiguring and psychologically distressing syndrome of lipodystrophy, but also with increases in blood cholesterol and lipid levels that actually translate into an increased risk for stroke and cognitive impairment (as is true for heart attacks). Recent research has also demonstrated that the use of medications that reduce inflammatory mediators of brain tissue damage, such as inhibitors of tumor necrosis factor-alpha, are not required for systemic HIV treatment. Finally, data confirms that the manipulation of neurotransmitter levels, particularly by increasing brain dopamine levels through the use of psychostimulants, is not related to the use of systemic anti-HIV medications.

FOR ADDITIONAL INFORMATION on these issues or other HIV topics of interest, please contact the Office of HIV Psychiatry at (703) 907-8642 or visit us on the Web at www.psych.org/aids.

Report on QIPS\NIAAA Track at APA's Annual Meeting

APA's Department of Quality Improvement and Psychiatric Services (QIPS), in collaboration with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) presented the research track "Alcohol and Health: New Discoveries and Future Directions" at APA's annual meeting in San Francisco. "The goal of the track was to bring the latest research findings to practicing psychiatrists," said Beatrice Eld, Associate Director of QIPS.

This year's track included featured lectures from Kenneth S. Kendler, M.D., and Marc A. Schuckit, M.D., with Dr. Kendler presenting the Distinguished Psychiatrist Lecture and Dr. Schuckit the Adolf Meyer Award Lecture. Both lectures addressed the significance and implications of advances in genetic research on substance use disorders.

Additionally, the NIAAA Track included several symposia, five workshops, and a number of research forums. Topics included treatment of alcohol use disorders and comorbid psychiatric diagnoses, managed care aspects of substance use treatment, and considerations of substance use in military veteran populations. Ms. Eld commented that this year's sessions were of particular interest to APA attendees, with many of the sessions drawing standing-room only crowds. "The research tracks were begun by APA's Council on Addiction Psychiatry more than 10 years ago and are now a regular feature of the APA Annual Meeting. The tracks have always been well-received and they have made a substantial contribution to the scientific quality of the meeting," she noted.

The National Institute of Mental Health and the National Institute on Drug Abuse (NIDA), with support from QIPS, each sponsor a research track of their own, with the three institutes featured at the annual meeting on a rotating basis. The 2010 meeting will present a track from NIDA; NIMH will develop a track for the 2011 meeting.

QIPS focuses on boosting the quality of care of patients by helping psychiatrists acquire necessary tools, information, and training. In addition to quality of care, the department focuses on issues related to substance use disorders and child psychiatry.

“The tracks have always been well-received and they have made a substantial contribution to the scientific quality of the meeting.”

— Beatrice Eld

Rising Suicide Rates in the Military: PRN and the Army Behavioral Health Practice and Treatment Study

With the number of suicides among active duty Army personnel reaching record highs in 2008, the psychiatric care of military personnel is clearly an urgent matter. Accordingly, one of APIRE's Practice Research Network's (PRN) current studies — the examination of how mental health practitioners are assessing and monitoring suicidal thoughts and behaviors in military populations — is especially timely.

In 2008, the Army confirmed 128 suicides among active duty and activated National Guard and Reserves personnel. By comparison, 115 suicides were recorded in 2007 and 102 in 2006 — the second- and third-highest years on record since the Army started tracking suicide statistics in 1980. Fifteen cases remain under investigation, but the current rate of 20.2 suicides per 100,000 soldiers is already higher than the national suicide rate. Lengthy tours in Iraq and Afghanistan, financial strain, and relationship problems have been among the contributing psychosocial stressors.

The Army Behavioral Health Practice and Treatment study, which APIRE is conducting with the Walter Reed Army Institute of Research (WRAIR), is obtaining a wide array of information on service members with specific psychiatric diag-

noses who receive treatment through the Army's military treatment facilities and clinics. APIRE staff is working with leading psychiatric research experts at WRAIR to develop a Web-based survey to examine mental health practitioners' practices in the assessment, treatment, and documentation of these psychiatric disorders and symptoms, including issues related to suicide.

"Examining routine clinical practices related to the assessment and treatment of suicidal ideation and behavior was a major priority at the outset of this study," said Joyce West, Ph.D., M.P.P., Principal Investigator of the study. "In addition to ascertaining the prevalence of suicidal ideation and behavior among service members, we will be able to identify clinical areas with the greatest gaps and opportunities for improving assessment and management of patients with suicidal ideation, behavior, and non-suicidal self-injury."

To achieve these outcomes, investigators reviewed available APA and Veterans Affairs/DoD practice guidelines for the assessment and treatment of posttraumatic stress disorder, major depression, substance use disorders, panic disorder, and traumatic brain injury to identify key evidenced-based recommendations, and to develop an online data collection instrument. All information collected will be compiled into a data base to help the Army track practice patterns and patients over time.

"We're hoping this clinical database will provide a valuable tool for the Army to continuously use to further strengthen its mental health care delivery system to ensure service members and their families receive the best available treatments," added Dr. West.

"Epidemiologic, neuroscience, and clinical research have taught us a great deal about suicide risk and protection in recent decades," said Eve Mościcki, Sc.D., M.P.H., Director of PRN. "Our best hope for preventing suicide—and it is preventable — is timely identification and appropriate treatment of mental and substance use disorders. It is our hope that our work with the Army can be an important step in saving lives."

— *Emily A. Kuhl, Ph.D.*

“Our best hope for preventing suicide—and it is preventable—is timely identification and appropriate treatment of mental and substance use disorders.”

— *Eve Mościcki, Sc.D., M.P.H.*

PHQ-9 Follow-Up: Enhancing Long-term Care for Clinical Depression

A recent study conducted by APIRE's Practice Research Network (PRN) suggests that routine use of measurement-based care for patients with depression is not only sustainable in the long-term but may be useful for clinicians outside of psychiatry as well.

The study is a follow-up to the National Management Depression Leadership Initiative (NDMLI), a joint project of the American Psychiatric Association, the American Academy of Family Physicians, and the American College of Physicians. The investigators, including PRN staff, examined psychiatrists' sustained use of the Nine-Item Patient Health Questionnaire (PHQ-9) for screening, diagnosis, and monitoring change in depression severity 12-months after the conclusion of the NDMLI. The study also assessed the degree to which participating psychiatrists encouraged colleagues within and outside of their practice — including those in other specialties — to use the measure as well.

At 12-months follow-up, approximately 87% of the psychiatrists were consistently using the PHQ-9 for screening, representing an increase from 56% at baseline. For diagnosing depression, 93% “usually or always” used the PHQ-9, up from about 50%. However, use of the measure for monitoring changes in symptoms showed the greatest improvement, from only about one-third at baseline to nearly 86% at follow-up.

“This study has really shown the value of the PHQ-9 for monitoring depression severity, which was the principal focus of the study,” said Farifteh F. Duffy, Ph.D., co-principal investigator on the

study and Director of Quality Care Research with PRN. “We wanted to improve the care of depression for existing and incoming patients by monitoring them over time for treatment response and remission.”

Along with assessing use of the PHQ-9, a secondary component of the study found that nearly all of the psychiatrists used patient registries to track visits and treatment progress. “We wanted to encourage our practices to have a registry of their patients with depression to help them identify this population and follow them more consistently,” said Dr. Duffy. “The registry has been highly successful in giving practices a framework for assessment, treatment, and follow-up.”

With this portion of the study complete, members of PRN will soon begin planning for a new initiative to enhance communication between psychiatrists, primary care physicians, and non-psychiatric mental health clinicians. Specifically, the researchers are interested in examining referral patterns to assess whether use of the PHQ-9 across specialties can improve communication and clinical care.

Investigators plan to publish their results from the PHQ-9 follow-up study later this year.

— *Emily A. Kuhl, Ph.D.*

“This study has really shown the value of the PHQ-9 for monitoring depression severity, which was the principal focus of the study.”

— *Farifteh F. Duffy, Ph.D.*

The Mentor's Column: Ongoing chats with distinguished research mentors

A supportive mentoring experience can be pivotal in developing and maintaining a psychiatric research career. In this ongoing column, *PRR* asks long-time mentors to share their perspectives.

Dilip V. Jeste, M.D.

Our current interviewee, Dilip V. Jeste, M.D., is the Estelle and Edgar Levi Chair in Aging and a Distinguished Professor of Psychiatry and Neurosciences at the University of California, San Diego. He has been mentoring trainees in psychiatry for about 25 years.



What are some qualities of noteworthy mentors from your past?

I like the definition of a mentor in Homer's *Odyssey* as a wise and trusted counselor. The mentor should have expertise in research, and this can be documented by having articles published in peer-review journals and by independent funding — especially from federal sources. But the mentor also needs to be a good person, someone who likes to teach and is giving. He or she should be a strong advocate for the mentee, and sometimes the mentor needs to be a psychotherapist too.

I've had many mentors, and the most important quality of the finest mentors was that they were role models and influenced me not only as scientists but also as people. For example, they were very generous, and built programs like families. When I started developing my own program, I wanted to be like one of those mentors. Another way they influenced me was as scientists. They were students of research and science, eager to learn new things, and highly ethical. They were both generous and generative.

How has being a mentor helped you to be a better researcher?

It's just like how being a reviewer teaches you how to write a better paper. When you are critiquing your mentee's work in a constructive way, you're learning so much about that area, and you're becoming a better scientist. It gives you a more objective perspective than when looking at your own work. Secondly, I see the mentee's progress and can see where she or he went right or went wrong, and one can apply those lessons to oneself.

Has mentoring taught you anything about yourself as a person?

I learned that I genuinely like mentoring. I find that if I have the right kind of mentee, mentoring becomes a pleasure, rather than work. Another thing I found is that I enjoy sharing my experience with somebody else. In some ways, that helps you to develop a friendship with your mentees. I am able to share my personal successes and failures with the mentee to an extent. In some ways, it's like working with your own kids, except that your goal is focused on helping their careers as inde-

Continues on page 13

Making the Most of a Psychiatric Research Fellowship

The right research fellowship can facilitate future job searches as well as grant funding. But how do you choose, and use, the fellowship that's best for you? Experts in the field outline some basic principles for young investigators seeking a research fellowship.

Fellowships are often targeted to applicants with particular levels of experience—some are designed to provide initial research experience to beginning investigators, and others to more seasoned researchers. Generally, prospective trainees should seek programs designed for their level of experience and research sophistication. While applicants should not be discouraged if they lack research experience, they should determine the level of experience preferred by, or acceptable to, specific fellowship programs.

“Some people are naïve regarding research and are getting into it for the first time, and others are coming through medical school with M.D.-Ph.D. degrees and already have a research track record,” said Joel Yager, M.D., Professor of Psychiatry at the University of Colorado School of Medicine and Professor Emeritus at both the University of California-Los Angeles and the University of New Mexico School of Medicine. “Fortunately, there are more research opportunities available than there are trainees, but not all fellowships will want to take someone naïve and green. Others will say, ‘jump in and let’s see what you can do.’”

Knowing which programs have a track record for producing research psychiatrists is also important, and trainees should gather information any way possible, from scouring the Internet to speaking with mentors and colleagues. Dr. Yager noted that the research networking breakfast at the APA Annual Meeting is being particularly helpful in bringing together young and experienced researchers.

Learning an institution’s track record also includes speaking with the individuals who helped develop that record — namely, former fellows.

Knowing what previous research fellows are doing, what their fellowship experience was like, and how they got along with their mentor are invaluable nuggets of information. Mentors themselves can be considered first-hand sources of information, and trainees should not shy away from asking tough but important questions.

Most trainees don’t know precisely what they will be doing down the road, but they should have some sense of what their future might entail. “The more specific the applicant is about what she or he wishes to be doing — the area of research, research questions and techniques — the better she or he can be at selecting where to go,” said Dr. Yager.

“I think there are always practical issues of mobility, finances, and relationships — if your partner or spouse needs a job, if the salary of the program is adequate to live on,” said Dr. Yager. “Also, what’s the exact job description? What are the rotations and

“What you have to size up are the opportunities that will await you at the end and the training resources the fellowship program provides.”



— Ronald Rieder, M.D.

responsibilities?”

Such candor can also come in handy for making certain the fellowship plays out as predicted. “You can’t be bashful,” warned Ronald Rieder, M.D. Professor of Psychiatry and vice-chair for Education in the Department of Psychiatry at Mt. Sinai School of Medicine. “You have to state, ‘In order to progress, I need a first author publication.’ Do not expect that your mentor is going to say, ‘I know you’re going to need this, so I’m going to make sure you’ll have one.’”

Once obtaining a fellowship, Dr. Rieder advises trainees to stay vigilant. “What you have to size up are the opportunities that will await you at the end and the training resources the fellowship program provides,” he said. This includes assessing how funding sources, such as the National Institutes of Health and the National Alliance for Research on Schizophrenia and Depression, are allocating grant monies.

“If you want to have a job when you finish, you should see what the institutions are stressing and who is getting funded,” said Dr. Rieder. “Right now, the predominant set of opportunities is in translational research and in health services. You should know if the research fellowship provides training in those areas.”

Along with acquiring basic research skills, such as learning statistics and methods, trainees need to ensure that they clear the necessary hurdles while on

fellowship — obtaining a lead authorship on a data-based manuscript, finding co-mentors to collaborate on a grant application, and acquiring early reviews on draft grant applications, as examples.

“Get advice from your mentor as to what a productive project that wouldn’t take too long would be,” said Dr. Rieder. “You really want to think about what could be done in a year, so it would give you a database to be written up and submitted, and within 2 years would give you a publication.”

Medical residencies are structured and organized such that trainees know exactly what to expect and what the outcome will be. However, research fellowships, according to Dr. Rieder, are not nearly as predictable.

“In a residency program, there’s a schedule in which residents rotate on a planned development course. All they have to do is do what they’re told, and they’ll end up being psychiatrists,” he said. “It’s very possible, though, in a research fellowship to end up incapable of proceeding as an independent researcher.”

Trainees should not assume that fellowship will automatically lead to a research position, but plenty of non-research jobs, such as academic teaching and consultation and liaison work, may potentially allow psychiatrists to engage in scientific pursuits part-time. In order to increase the odds of obtaining work, Dr. Rieder emphasized the importance of taking initiative and developing self-direction, which may not have been emphasized during residency.

“In a way, you have to think about what your education needs are, in addition to finding a way to fulfill them, using either the resources available or using resources outside the institution,” he added.

Tips

Gather Information

- Scour the Internet
- Speak with mentors and colleagues
- Attend APA’s annual research networking breakfast

Know the Institution

- Read about previous research
- Ask about fellowship experiences and relationships with mentors

“The more specific the applicant is about what he or she wishes to be doing, the better he or she can be at selecting where to go.”



— Joel Yaeger,
M.D.

It's equally important that the fellowship works for the trainee as it is that the trainee works for the fellowship. To accomplish this, Drs. Yager and Rieder underscored the importance of assessing one's own abilities and knowing when to push beyond perceived limitations. Taking on too many projects, lacking focus, and becoming distracted are common pitfalls that can be avoided by knowing who you are and what you want.

"Be judicious in the application of your own time and effort, and be willing to try things," said Dr. Rieder. "But also be willing to say, 'I can't do this.'" "People who are vague or unsettled are just going to be flying through," added Dr. Yager. "Just know yourself and make certain you're suited for a research career."

— *Emily A. Kuhl, Ph.D.*

Mentor's Column continued from page 10

pendent investigators. Even when your own kids leave home and become independent, they continue to be a part of the family, and you hope the same will be true of your mentees.

What is your favorite aspect of being a research mentor?

In terms of my favorite aspects, probably the most rewarding one is watching the mentees' growth and development. When you're seeing someone who just finished her or his residency, and then a few years later has obtained grants and is an independent investigator, that's one of the biggest satisfactions in life — even more so than when you get your own grant.

Learning from mentees is also one of my favorite aspects. When you start out, they're at the receptive

end, and you tell them what to do to get better. A few years later, if I'm writing a grant, the mentee starts pointing out its weaknesses and how to make it better. It's so rewarding to feel that you've done something to help them become your teacher.

What is the most difficult aspect of being a research mentor?

The dream trainee is someone who shares your value system, works hard, is very collegial and so forth. When a mentee does not share your value system or work hard, it becomes difficult. If they don't show up on time or promise something and don't deliver consistently, it's hard. By and large, though, the positive aspects of mentoring far outweigh the negative ones, and that's what makes it so much fun.

The Mentor's Column

The Mentor's Column is a recurring feature for prominent researchers in psychiatry to discuss important aspects of mentoring. If you have a question or topic you would like to hear a featured mentor speak about, send an email to the PRR staff at prr@psych.org. Please be sure to write "Mentor's Column" in the subject line of your email.

Research Opportunities for Young Investigators

The APA and the American Psychiatric Institute for Research and Education administer a number of research training awards in concert with industry sponsors. More information on these awards can be accessed online at: www.psych.org/MainMenu/Research/ResearchTrainingandFunding.aspx.

The APA/AstraZeneca Young Minds in Psychiatry Awards recognize and promote promising work from physicians who are not more than five years past residency training. Awards are made for research in Bipolar Disorder and in Schizophrenia. Two awards will be made to U.S. physicians and five awards to physicians from outside the U.S. Each award is a \$45,000 (for physicians in developed nations) or \$30,000 (for physicians from developing nations) and are unrestricted career-development awards. Nations are classified as “developing” in accordance with World Bank standards.

Application deadline: October 30, 2009

The APA/Kempf Award for Research Development in Psychobiological Psychiatry recognizes a senior researcher and a young research psychiatrist in a mentor-trainee relationship. The senior researcher is awarded \$1,500; the junior investigator is awarded \$20,000, payable to the applicable institution for the support of the awardee’s research career development. **Application deadline:** October 14, 2009

The APA/Lilly Psychiatric Research Fellowships are designed for physicians who have completed residency training, demonstrate significant research potential, but have not had extensive research training. Two individual trainees will be selected. Two stipends of \$45,000 each will be paid to the applicable institution, for disbursement to each fellow.

Application deadline: October 14, 2009

The APA’s Research Colloquium for Junior Investigators’ purpose is to provide guidance, mentorship, and encouragement to young investigators in the early phases of their training. Held during the APA Annual Meeting, this all-day workshop provides junior investigators with an opportunity to obtain feedback about their past, present, and future research from mentors in a small group setting as well as general information about career development and grantsmanship. **Application deadline:** November 16, 2009

The APIRE/Janssen Resident Psychiatric Research Scholars Program is designed to encourage promising postgraduate (PGY-1, PGY-2 or PGY-3) psychiatry trainees to enter the field of psychiatric research. The program is a one-year fellowship with a stipend of \$2,500 and focuses specifically on clinical and health services research in all areas of psychiatric research. Emphasis is placed on special mentoring and career enrichment programs, both at the APA Annual Meeting, and throughout the year.

Application deadline: January 15, 2010

More Info:

Ernesto Guerra
eguerra@psych.org
(703) 907-8622

Improving Care for PTSD: Self-Assessment Tools for Clinicians

The Practice Research Network (PRN) of the American Psychiatric Institute for Research and Education recently published a report to help clinicians self-assess whether they're providing up to date evidence-based care for posttraumatic stress disorder (PTSD). The paper, entitled "Performance in Practice: Clinical Tools to Improve the Care of Patients with Posttraumatic Stress Disorder," will be presented as a part of a symposium on PTSD at the upcoming annual meeting of the Institute for Psychiatric Services (IPS; see page 16). It was recently published in the journal *Focus* (2009; 7:186-203) and mirrors a similar article PRN produced last fall on guidelines for assessing depression (Fochtmann et al., *Focus* 2008; 6:22-35).

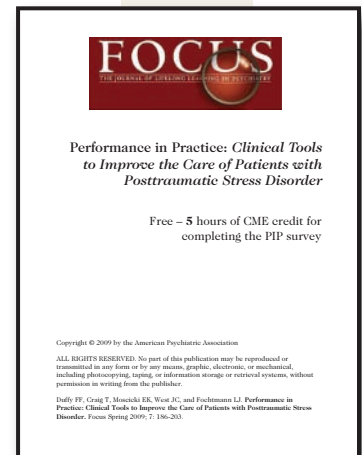
"With military populations and those that have experienced a catastrophic event, like Hurricane Katrina or the events of September 11th, clinicians are sensitive to the potential for PTSD," said Farifteh F. Duffy, Ph.D., Director of Quality Care Research with PRN and the paper's lead author. "But there are many events that can precipitate PTSD, and clinicians need to be aware of that in their routine care of patients that walk through the door."

The study was designed as part of the American Board of Medical Specialties' and the American Board of Psychiatry and Neurology's efforts to bridge the gap between evidence-based practices and actual clinical practices. The boards are currently implementing certification programs intended to increase the quality of patient care. Among the programs' requirements is that clinicians conduct self-assessments of practice by reviewing their care of patients, including thorough diagnostic assessment.

The paper provides two sample measures to aid clinicians in these self-assessments. One is a retrospective chart review to determine whether a patient exhibited symptoms of PTSD and was being treated for it. The second is a performance-in-practice evaluation tool to be completed immediately following a clinical visit. It assesses whether the clinician performed a thorough assessment of factors that may increase risk for developing PTSD, or exacerbate an already existing PTSD condition. Such factors include experiencing a traumatic event, sustaining a traumatic brain injury, having a history of suicide attempts or self-injurious behaviors, and/or lacking a social support network.

"What we're really trying to do now is to get practitioners used to the idea of doing self-assessment practices," said Dr. Duffy, adding that clinicians' ideas of what constitutes a "traumatic event" are frequently too narrow. War and physical or sexual abuse are well-recognized triggers for PTSD, but events such as motor vehicle accidents, natural disasters, or the accumulation of other overlooked and seemingly minor stressors over time may also precipitate PTSD," she noted. "That's why it's so important to look at life experiences. It is far beyond just war."

The paper concludes with a review of evidence-based treatments and assessment guidelines set forth by the APA as well as the Department of Defense and Veterans Affairs Health Care System. Funding for the paper came in part from the Department of Defense Concept Award grant and the American Psychiatric Foundation Barriers to Care grant. Clinicians who complete Appendix B of the article are eligible to receive 5 hours of CME credit.



Upcoming Events at IPS

Fourth Annual Health Services Research Track

The purpose of the track is to highlight the contributions of health services research to the delivery of effective psychiatric services and sound policy. Through selected lectures and workshops, the HSR track focuses on the importance of evidence based knowledge as an essential framework for implementing service programs and policy. Included in the track is the Health Services Research Breakfast, open to all IPS registrants, as the venue for presenting the Health Services Research Senior Scholar and Early Career Awards. All events will take place at the Sheraton New York Hotel and Towers.

FOR FURTHER INFORMATION on the Health Services Research Track, please contact Harold Goldstein, Ph.D., (703) 907-8623, email: goharold@psych.org

Friday, October 9, 2009

- 8:00–9:30 a.m. **Health Services Research Breakfast**
LENOX BALLROOM, 2ND FLOOR
- 10:00–11:30 a.m. **Workshop 14: Screening and Brief Interventions for Substances in Medical Settings: Implications for Psychiatry**
Chair: Wilson M. Compton, M.D.
Participants: Thomas Babor, Ph.D., Jon Ebert, M.D., Bonnie McRee, M.P.H., Richard Ries, M.D.
CONFERENCE ROOM F, LOWER LOBBY
- 1:30–3:00 p.m. **Lecture 13: Treating Blues in the Land of the Blues: Telecommunications in the Delivery of Mental Health Services to Underserved Populations**
Grayson S. Norquist, M.D., M.S.P.H.
CONFERENCE ROOM E, LOWER LOBBY

Saturday, October 10, 2009

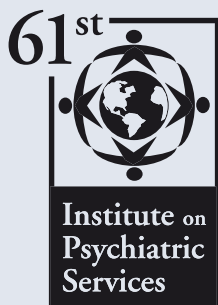
- 1:30–3:00 p.m. **Workshop 29: Advancing the Science of Implementation**
Chair: David Chambers, D.Phil., M.S.C.
Participants: Leif Solberg, M.D., Kenneth Wells, M.D., M.P.H., Douglas F. Zatrack, M.D.
CONFERENCE ROOM H, LOWER LOBBY

Paper Presentations

**PTSD in Military Populations:
Translating Research into Practice**
Chair: Darrel A. Regier, M.D., M.P.H.
Participants: Farifteh Duffy, Ph.D., Charles Engel, M.D., Matthew J. Friedman, M.D., Paula Schnurr, Ph.D., Robert Ursano, M.D., and Joshua Wilk, Ph.D.
Discussant: Elspeth Ritchie, M.D.

Thursday, October 8, 2009
2:00–5:00 p.m.

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Save the date now to attend the American Psychiatric Association's **61st Institute on Psychiatric Services**, APA's leading educational conference on clinical issues and community mental health to meet the service needs of people with severe mental illness. Check out our website at www.psych.org/IPS.

Pride and Practice: Bringing Innovation Into Our Treatments

This four-day event will feature popular networking events, more than 100 exhibits that complement the educational program, and over 200 expertly-led educational sessions on topics including: Violence, Trauma, and Victimization; Social and Community Psychiatry; Psychopharmacology; Resident and Medical Student Concerns; Disorders; Cross-Cultural and Minority Issues; Child and Adolescent Issues; Treatment Techniques and Outcome Studies; Cognitive Disorders; Health Service Research; Mood Disorders; Schizophrenia, Addiction, and much more...

Who Should Attend?

- All APA Members
- Psychiatrists and mental health professionals in community practice or the public sector, including state and Veterans Affairs hospitals, community clinics, jails and prisons
- Psychiatric Administrators
- Mental health professionals interested in social issues that have an impact on patients and their families
- Minority psychiatrists and International Medical Graduates
- Psychiatric Residents (only \$60 for advance registration)
- Nonmember Residents and Advocacy Group Members (only \$85 for advance registration)
- Medical Students (free registration)

Why Should You Attend?

- This activity has been approved for CME credit and CEs have been applied for
- Receive a 40% discount on APA member registration fees
- Network with colleagues at receptions and other events
- Valuable exhibit hall prizes drawn each day
- **Immersion Courses are NEW and FREE this year.** They offer intensive all day sessions which will provide a new and clinically applicable skill set to attendees. A certificate of participation/certification will be available for some sessions.

The IPS is going "GREEN" this year; therefore, the *Preliminary Program*, which includes registration, housing, and travel information will be available online only in May at www.psych.org/IPS. Online registration and hotel reservations at the Sheraton New York Hotel and Towers will begin on June 1.



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